Association for
Palliative Medicine

COMMENTARY APM WORKFORCE SURVEY 2015

ASSOCIATION OF PALLIATIVE MEDICINE

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EXECUTIVE SUMMARY

Executive Summary

KEY MESSAGES:

- As a UK medical specialty we have the highest % of female trainees 88% and similarly 74% for Consultants.
- Overall 61% of UK Consultants are LTFT and is rising each year and for trainees LTFT = 35.3%.
- Current rate of expansion is falling for UK Consultants at 471 FTE compared to 454 FTE in 2014, an increase of 3.6 % compared to 10% increase by head count with the need to focus on this message to deaneries/LETBs.
- Consultants by country: England 505 (385 FTE), Scotland 49 (39 FTE), Wales 35 (29.2 FTE), Northern Ireland 20 (17.3 FTE) and Republic of Ireland 35 (33.6 FTE).
- 31% of the Consultant workforce is aged >50years of age (RCP Census 2014-15) and APM survey 2015.
- Vacancy rate is 7.6% of the Consultant workforce and an increase in anticipated retirement rate of 10/year for 2015-19.
- Expansion of NTNs: Current estimate of need for the UK is 646 FTE (838 headcount) based on 2.5 FTE per 250,000 population i.e. there is currently a shortfall of 175 FTE for a 5-day service and additional FTE required for 7-day services.C
- Impact of loss of LATs in 2016 for hospices: re need to fund LAS posts for maternity leave and OOP experience and the reductions in tariff could result in the potential withdrawal of training posts if hospices are financially disadvantaged. Major risk of not meeting the curriculum if hospices financially become less willing to train.
- No current recruitment problems in 2015 with all ST3 posts filled and no vacant NTNs. There are Insufficient NTNs given the existing Consultant vacancies of 46 posts (7.5%), the overall unmet need and geographical variation in Consultant posts. RCP data for 2013-14 – East Midlands has the lowest number of Consultants at 1FTE > 215,000 population followed closely by Eastern and Wessex. Consideration needs to be given to recruiting additional funded NTNs in these geographical areas, and specifically in LETB areas where Consultant recruitment is difficult and a greater increase in both training numbers and capacity are required.
- Despite detailed data from APM and SAC, HEE and LETBs use information from Trusts that underestimates both the headcount and FTEs for Palliative Medicine trainees/Consultants and their required expansion e.g. 272 FTE Consultants reported by HEE for England. The SAC 2015 data reports 385 FTE. Across England engagement with LETBs has been difficult, in many places there is either disinterest or lack of understanding about NHS and voluntary sector palliative care workforce.

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- It remains challenging to interface with deaneries and LETBs re Palliative Medicine workforce needs but vitally important we do so for 2016/17 e.g. submission of information to HEE on workforce numbers and planning.

- Just over half (51%) of the SSAS doctors who responded to the SSAS 2015 survey are on the new 2008 contract and only 90% have a regular appraisal.

- Need to determine the impact of implementation of Shape of Medical Training. Whilst we have currently agreed to deliver training and future hospital services as part of acute medical care with other physician colleagues, there must be clear recognition of the need to not only maintain, but also to expand both training and service delivery in the community and for hospices. This change will alter the distribution of our medical workforce undertaking Palliative Medicine and those who will also practice acute medicine.

- The current pay structure for non-resident on call within the junior doctors' contract in England is set to significantly change. Combined with the changes to pay progression this may affect the choices junior doctors make about entering the specialty, and the choices made about taking time out of programme for research etc.

In 2015-16, the most significant challenge to all medical workforces remains the current financial climate in the public sector and its impact on the voluntary sector. As predicted there has been a significant slowing of consultant expansion.

APM WORKFORCE SURVEY 2015

A total of 1202 questionnaires were issued; 94% to APM Members.6% of questionnaires to non-members understood to be working in palliative medicine in the UK and the Republic of Ireland. In total 688 questionnaires were completed, a 57% response rate.

BACKGROUND

England: HEE published investing in people: Developing people for health and healthcare. Proposed Education and Training Commissions for 2015/16: Workforce Plan 2015/16, which despite extensive information from the APM and the Palliative Medicine SAC reported underestimates of numbers of training posts and consultants. As a specialty there has been no reduction in training numbers in 2015 and 2016. It remains challenging to interface with LETBs re Palliative Medicine workforce needs but vitally important we do so for 2016/17, and submit information to HEE on workforce numbers and planning for England.

- In England, 54.6% 176/282 of Consultant responders work full-time (53% in the UK; APM 2015). SAC data 2015 indicated a total of 505 consultants with 31% FT compared to 33% in the UK.

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- 64% (130/202) of Registrars (SAC 2015) are in full-time posts compared with 65% UK-wide, (SAC 2015) and 66% (APM 2014) respectively.
- 61 of 553 respondents (11.3%), held academic positions vs. 11% across the UK. (APM 2015).
- 73% of consultants who responded employed by the NHS, 23% by voluntary sector hospice and 3.8% by an academic institution (APM 2015).
- 207/261 (79%) of consultant posts receive funding from the NHS, 28 (11%) from a charity, 92 (35%) from a voluntary hospice and 31 (12%) from an academic institution.

Scotland: Following the decision approved by the Reshaping Medical Workforce Project Board that NES should work with whole time equivalent (WTE) numbers rather than trainee establishment numbers. The Scottish training Programme in 2014 received one additional WTE, which increases the number of trainees on the Programme from 13 to 14 and included in National Recruitment from April 2015.

- In Scotland 55.6% of Consultant respondents work full-time (53% in the UK; APM 2015). SAC data 2015 reported 49 consultants with 39% FT.
- 50% (7/14) of Registrars (SAC 2015) are in full-time posts compared with 65% UK-wide, (SAC 2015) and 66% (APM 2014).
- 4/37 (10.8%) of respondents hold academic positions vs. 11% in the UK. (APM 2015).
- 53% of Consultant respondents employed by the NHS and 47% by voluntary hospices (APM 2015).
- 8/17 (47%) of consultant posts receive funding from the statutory sector, 12 from a charity, 5 from a voluntary hospice, and 3 from an academic institution.

Wales: It is not anticipated that there will be a significant further expansion in medical workforce in Wales. These calculations are based on the existing models of service delivery and workforce. There remains uncertainty, depending on the outcome on the current consultation on the 'Shape of Medical Training' in making future projections difficult for the medical workforce.

- In Wales, 45% (9/20) of Consultant respondents work full-time (53% in the UK; APM 2015). SAC data 2015 reported 35 consultants with 51% FT.
- 85% (11/13) of Registrars (SAC 2015) are in full-time posts compared with 65% UK-wide, (SAC 2015) and 66% respectively (APM 2014).
- 7 of 34 respondents (20%) held academic positions vs. 11% in the UK. (APM 2015).
- 84% of Consultant respondents hold an NHS contract and 16% by a voluntary hospice (APM 2015).
- 17/19 of consultant posts indicated that funding was received from the statutory sector, 5 posts from a voluntary hospice, and 9 from a charity and 3 from an academic institution.

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Northern Ireland: Workforce issues are under discussion with the Medical Workforce Planning Lead at the Public Health Agency, currently no proposed changes in trainee numbers.

- In Northern Ireland 10 consultants responded to APM survey 2014 2015 (3 full-time and 7 < full-time) (53% in the UK; APM 2015) 7 registrars. SAC data 2015 reported 20 consultants (45% FT) and 7 registrars (50% FT) compared with 65% FT UK-wide (SAC 2015), and 66% Registrars (APM 2014).
- For 8/9 Consultant respondents receive NHS funding, 1 receives funding from a charity,2 from an university and 5 from voluntary sector hospices.(APM 2015).
- Most Consultants participate in on-call for Hospice units, including those who work primarily in hospitals. In one Specialist Palliative Care Unit, Consultants participate in a first on-call Rota. There is currently no commissioned out-of-hours cover for hospitals in Northern Ireland. There is variable out-of-hours Consultant cover for Community Teams.

UK ON-CALL DATA

Total number of UK Consultants providing on-call was 278/330 representing 84.2% of respondents. 5% (15) were 1st on call, 57% (158) second on call and 38% (105) first and second on call.

- 79% of on-call Consultants covers out of hour's emergency admissions.
- % of Consultants receiving contracted PAs: range from 51-53% for telephone advice, 49-53% for face to face contact across the services; 80% hospital and community and 45% for hospices for emergency recall.
- On-call more frequent than 1 in 4 ranges for second on-call 27 - 33%; first and second on call from 71 - 95%, and 71 -77% for first on call only.

Republic of Ireland: Expansion in consultant posts remains slow and impacts significantly on the availability of consultant posts for qualified trainees. Workforce information has been submitted by RCPI to HSE as part of a workforce review. The National Clinical Programme for Palliative Medicine is seeking to develop a model of care for palliative care delivery in Ireland. A workforce planning exercise across all disciplines including Palliative Medicine will be required to inform and develop this model of care. The National Clinical Lead and Dr Feargal Twomey APM lead for Ireland are working up the Palliative Medicine Workforce component of this, which will include sense-testing existing national policy (2003) and the 2012 UK Commissioning Guidance for use in the Irish setting.

This year's response rate for those doctors working in the Republic of Ireland to whom the survey was circulated (27/30 = 90%) was encouraging. Twenty-one of these were in consultant posts. The small number of trainee and SSAS data makes any valid comparison/commentary for these groups not possible.

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Notable findings within ROI data (2015) included:

- 94% of Consultant responders work full-time (53% in the UK)
- 93% of ROI Specialist Registrars are in full-time posts compared with 66% UK-wide.
- 10/30 (33%) respondents, in the ROI held academic positions vs. 11% in the UK.
- 80% of respondents indicated that 10 posts received funding from the statutory sector, 1 had academic and one received charitable funding.
- 63% provide on call with 10% of Consultants in the ROI provided first on call only, 50% provided second on call only and 40% undertook first and second on call.

SSAS DOCTORSC

Total number of SSAS Doctors and other non-training grades that responded (APM 2015) was 122 in UK and 2 in ROI. 81% were female. Overall 38% were >50 years of age. In total, 73 % were working less than full-time.

Of 163 SSAS doctors responding to an additional SSAS 2015 survey just over half (51%) are now on the new 2008 contract and only 90% having a regular appraisal. Trying to identify SSAS doctors working in palliative care who are not members of the APM is difficult, and they could be designated as a 'lost tribe' in that we have no information about them or from them.**C**

CONSULTANT WORKFORCE

- SAC 2015 data for UK Consultant numbers 609 (471 FTE) compared to 555 (454 FTE) in 2014 due to more accurate data collection. Consultant expansion has fallen to 3.4% compared to 5.3% in 2012.
- RCPI expansion rate of 0 % i.e. no change in 35 Consultant posts.
- Overall 61% of UK Consultants are LTFT and is rising each year
- UK Consultant % vacancy rate slightly lower 7.6%, 46 posts (31.45 FTE).
- AACs 2014 for England, Wales and N Ireland: - 68% appointed compared to previous year 67%. Note this applies only to those with a RCP representative. Average AAC appointments 2010-2014 = 44/year.
- 50 expected retirements for 2016 -20 = average of 10 per year increasing over last 5 years from 4-5/yr.

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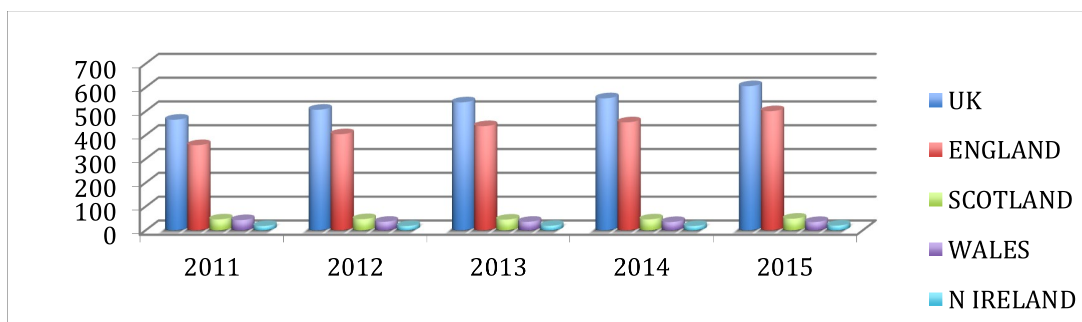
Table 1. Comparisons of APM Consultant headcount 2015 with RCP 2014 and SAC 2014-15 data.

Consultants	England	N Ireland	Scotland	Wales	UK	Eire
APM 2015	282	10	18	20	330	16
SAC 2014	454	20	46	35	555	-
SAC 2015 *	505	20	49	35	609	
RCP 2013-14	414	15	48	25	502	-
RCP 2014-15	427	15	51	26	519	-
RCPI 2015						35

Note * SAC data 2014 compared to 2015 under-reporting of consultant numbers hence 10% expansion compared to RCP increase of 3.4%.

For Ireland Consultant headcount remains at 35 (33.6 FTE) with three working LTFT. There are up to four new full-time consultant posts due to come on stream this calendar year. SpR numbers are 15 (14.5 FTE) at present with no immediate plans to expand the number of higher specialist training posts.Fig 1 Changes in UK Consultant headcount by Country 2011-15 (SAC data)



The RCP census 2014-15 (compared to 2013) for UK Consultant physicians identified 519 (502) palliative medicine consultants, with 427 (414) in England, 26 (25) in Wales, 51 (48) in Scotland and 15 (15) in Northern Ireland. Expansion rate of 3.4% compared to expansion rate for all specialties of 4%. The Palliative Medicine workforce has a higher proportion of female consultants (74%) than most other medical specialties. Across the specialty 61% of female and 14% of male Consultants are working less than full time. The average intended retirement rate (at age 65 yrs) of 10/yr (2015-19) and 11/yr in each of the next 5 years. Between 2014 and 2018 average intended retirement age ranges from 59.8 to 61.7 yrs reflecting the high % of female Consultants.

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Geographical distribution of Consultant posts across UK (2014): The East Midlands, Eastern and Wessex LETBs have the lowest FTE Consultants i.e. 1 FTE for > 215,000 population, however across UK the published RCP estimated need is 1 FTE for 160,000 population, however <40% work FT represents a need of 2.5 FTE /250,000 population.

Table 2. shows estimated Consultant workforce numbers and FTE for 2015 for each country on the basis of 2.5 FTE/250,000 in UK compared to current provision (SAC data 2015). With participation ratio of (0.76 - 0.95) for FTE and head count in each country.

Table 2. Estimates for each country in UK and Eire – <40% full time

Country	Population Est.ONS Millions (2014)	RCP estimate[1]		SAC 2015 data		Participation Ratio
		Headcount	FTE	Headcount	FTE	
Wales	3.1	37.0	31.0	35.0	29.2	0.83
N Ireland	1.8	20.7	18.0	20.0	17.3	0.87
Scotland	5.3	66.3	53.0	49.0	39.2	0.80
England	54.3	714.0	543.0	505.0	385.0	0.76
UK	64.6	838.0	646.0	609.0	471.0	0.77
Eire	4.05	42.5	40.5	35.0	33.6	0.95

Overall significant cumulative consultant expansion occurred in the last decade but has declined over the last 5 years. Noting that there has been an increase in the proportion of Consultants working less than FT, and using 2.5 FTE/250,000 populations would represent 646 FTE needed for UK (Table 2). A significant shortfall exists in England with 385 FTE Consultants in 2015 compared with an estimated need of 543 FTE. There is a discrepancy between RCP and SAC data for the UK in terms of consultant headcount and FTE likely to represent those who do not hold a NHS contract.

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Table 3.Type of clinical service by mean PAs for services delivered by UK consultants – CONTRACTED PAs as Direct Clinical Care (DCC)

Type of Clinical Service	Mean PAs /week	Consultants N = 330
Hospice Inpatient Beds	2.5	207
Hospice Day Centre	0.4	102
Hospice Outpatient Clinic	0.9	142
Hospital Specialist Palliative Care Team	3.0	211
Hospital Specialist Palliative Care Dedicated NHS Inpatient Beds	0.5	71
Hospital Outpatient Clinic	0.8	115
Community Specialist Palliative Care Team	2.0	191
Community Outpatient Clinic	0.4	80

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TRAINEES

Registrars

Specialist Advisory Committee (SAC 2015): In October 2015, the SAC reported 236 (204 FTE) palliative medicine registrars in the UK. Overall, 35% of registrars were working LTFT. The breakdown for these posts was: 202 (174.7 FTE) in England, 14 (10.4 FTE) in Scotland, 13 (12.5 FTE) in Wales and 7 (6.4 FTE) in Northern Ireland, 15 (14.5 FTE) registrars in Republic of Ireland. The number of OOP trainees in UK was 25 post-holders and 20 on maternity leave. In England there were 7 academic fellows and 4 academic clinical lecturer posts occupied. ST3 recruitment for August 2015 was 35 posts. 43 CCTs were achieved in 2015. There are 37 CCTs expected in 2016. The projected average number of CCTs per year over next 3 years is 45 to 50.

Table 4. Comparisons of Trainee Numbers RCP and SAC data

Registrars	RCP 2014-15	SAC 2015
UK	219	236
England	192	202
Northern Ireland	6	7
Scotland	12	14
Wales	9	13
Ireland * RCPI	15	

RCP Census 2014-15 reported 88% of trainees were female the highest medical specialty.
Currently there is no problem in recruiting to NTNs but probably insufficient NTNs given the existing Consultant vacancies of 46 posts, overall unmet need and major geographical variation. Consideration needs to be given to the recruitment of additional funded NTNs in these geographical areas, recognizing the effect of the large proportion of female and LTFT trainees who may not be able to apply outside their training region.

The most important variables in the current financial climate remain the creation and funding of new consultant posts and the continued funding of existing consultant vacancies. Overall there remains a potential risk of a mismatch of CCT holders in regard to available consultant posts although there is a consistent Consultant vacancy rate of >40 posts and no mismatch in trainees obtaining Consultant posts over the last 5 years. One of the consequences could be the facilitation of recruitment of consultants to regions that are currently under supplied.

Main issues confronting workforce planning are extending the current patterns of 7 day services and the potential added commitment to acute medicine, in the context of delivering out of hours cross-site working in community, hospice and hospital settings and securing the recognition that additional consultant numbers will be needed to achieve this.

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Challenges

In all countries, the consequences of financial restraints and envisaged changes to education, training and workforce planning are still a major concern; in particular in England the impact of the Learning and Education Training Boards. There is currently no commitment to national workforce planning or standards. In addition, there is the impact of changes to the Madel funding of basic salaries for FY2 and Registrar trainees, by Health Education England. The APM made representations to HEE and our current understanding is that hospice placements and less than full time training will not be subject to the changes in national tariff in 2015/16; however, we await clarification from local LETBs as to how future funding arrangements will be implemented.

For all countries in the UK and Ireland a major question is do our current and proposed future models of medical care meet the current need and the unmet need for access to Palliative Care services?

The current proposed changes to medical training may shorten the length of specialty training and that more medical specialties will have involvement in acute general medical intake. These are being considered by the specialties and Colleges but will ultimately be determined by the response of the different Departments of Health. The anticipated changes in service provision and in the Shape of training review will influence the traditional roles of hospices, community and hospital palliative care teams and the type of medical workforce. These proposals will impact on the format of the delivery of 7-day access to palliative medicine, continuity of care, our relationship to the wider hospital and community service provision, and the promotion of general internal medicine skills across the medical workforce in hospital and community, in meeting the needs of the frail elderly and the rising tide of acute medical admissions.

Overall, it is important that although we may know the current numbers of our workforce but we do need to identify the future need and anticipate unmet need so that we train, develop and deliver a workforce that is fit for purpose. There remains uncertainty, depending on the outcome on the implementation of 'Shape of Medical Training' about what the impact of this will have in making future projections more difficult for the medical workforce at this juncture.